DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FILE COPY

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 00 - 008
2. STATE: Alaska
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
JAN - 8 2001

4. PROPOSED EFFECTIVE DATE: October 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250 – 447.252 and 42 CFR 447.256 – 447.299

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 0 (P&I)
b. FFY 2001 $ ~~(3,300,000)~~ (3,700,00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A
"Pages 17-20" (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A
Pages 17-20 (P&I)

10. SUBJECT OF AMENDMENT:
Revision of Disproportionate Share Calculations

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Does not wish to comment

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Julie Nuckols for
13. TYPED NAME: Bob Labbe
14. TITLE: Director, Division of Medical Assistance
15. DATE SUBMITTED: 12/29/00

16. RETURN TO:
Division of Medical Assistance
P.O. Box 110660
Juneau, Alaska 99811-0660

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JAN - 8 2001
18. DATE APPROVED: 1/5/1

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT - 1 2000
20. SIGNATURE OF REGIONAL OFFICIAL: JUL 19 2001
21. TYPED NAME: TERESA L TRUMBLE
22. TITLE: ASSOCIATE REGIONAL [illegible]
DIVISION OF [illegible]

23. REMARKS:
P&I changes authorized by the state on 6/29/01

"POSTMARKED: 12/29" (DATE) Anchorage (CITY)

FORM HCFA-179 (07-92)

Instructions on Back

(2)(b) above. If an Out-of-State hospital does request a DSH adjustment, they must supply all necessary data in order for the State to complete the calculations.

(6) All facilities that qualify under (1)(a) or (1)(b) of this subsection receive a minimum 1% add-on to their reimbursement rate for allowable charges. This add-on is paid each time a claim is processed. Under sections (2), (4), and (5) of this subsection, facilities may also choose to receive DSH payments in either an annual lump sum payment, based on qualifying year information, or as a percentage add-on to the payment rate paid on claims processed through out the rate year.

(7) The percentage of disproportionate share payment is not subject to the limitations of 100% of charges.

(8) The total disproportionate share payments to all hospitals in the aggregate will be limited to the Federal disproportionate share cap established for the State of Alaska. A comparison of the Federal cap to the State's estimated total disproportionate share payments for the federal fiscal year will occur before any payments are distributed to qualifying hospitals.

(9) If the State's estimated total disproportionate share and/or IMD payments exceed the Federal cap for those payments, the State will proportionately reduce the disproportionate share and/or IMD payments to be made to facilities in the state.

(10) The State will recalculate and reallocate the disproportionate share eligibility and payments for all hospitals and will recoup payments from all hospitals on a prorated basis if the disproportionate share eligibility and payment for any hospital must be recalculated as a result of a final commissioner's decision in an administrative appeal or of a court decision that would cause the total disproportionate share payments to exceed the federal allotment and/or the IMD cap for the federal fiscal year in which the payment rate was in effect.

(11) Facility Specific Limit - Hospitals' DSH payments are limited to: The Cost of Services to Medicaid patients less the amount paid by the State under the non-DSH payment provisions of the State Plan; plus the Cost of Services to Uninsured Patients less any cash payments made by them or on their behalf for those services.

An Uninsured Patient is defined as an individual who's costs are not met because they have no insurance or other resources.

Cost of Services is total allowable costs of the hospital as defined in the State Plan divided by total patient days of the hospital times Uninsured Patient Days or Medicaid Patient Days as applicable.

(12) This section outlines methods and standards for calculating a disproportionate share adjustment to each prospective payment year beginning during the period this plan is effective. For purposes of making the DSH calculations in this section:

a. a "Qualifying" year means a hospital's base year for its prospective rate year beginning immediately after the qualifying date of June 1 of each year. The base year is the hospital's fiscal year ending 24 months before the prospective rate year.

b. "inpatient days" means patient days at a licensed hospital that are calculated to include: injured, disabled or sick; substance abuse patients hospitalized for substance abuse detoxification; swing bed patients whose hospital level of care is reduced to nursing facility level without a physical move of the patient; patients hospitalized for rehabilitation services for the rehabilitation of injured, disabled or sick persons; patients in a hospital receiving psychiatric services for the diagnosis and treatment of mental illness; and newborn infants in hospital nurseries.

c. Not to include Medicaid covered and non-covered patient days related to the treatment of patients: at licensed nursing facilities; in a residential treatment bed; on leave of absence from a hospital beginning with the day the patient begins a leave of absence; who are in a hospital for observation to determine the need for inpatient admission; or who receive services at a hospital during the day but are not housed there at night.

d. "institution for mental disease" or "IMD" means a hospital of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services; whether an institution is an institution for mental disease is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not the facility is licensed as such.

XII. Exceptional Relief to Rate Setting:

If the rate setting methodology results in a permanent rate which does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the facility may apply to the deputy commissioner of the department for exceptional relief from the rate setting methodology. This provision applies to situations where a facility is

forced to close or dramatically reduce quality of care to its residents due to the inadequacy of its payment rate. To apply for exceptional relief, the facility's application should include:

1. the amount by which the facility estimates that the rate should be increased to allow reasonable access to quality patient care provided by an efficiently managed facility;

2. the reasons why and the need for exceptional relief requested, including any resolution by the facility's governing body to support the reasons offered, and why such a rate increase cannot be obtained through the existing rate setting process;

3. the description of management actions taken by the facility to respond to the situation on which the exceptional relief request is based;

4. the audited financial statement for the facility for the most recently completed facility fiscal year and financial data, including a statement of income and expenses and a statement of assets, liabilities, and equities and a monthly facility cash flow analysis for the fiscal year for which the exception is requested;

5. a detailed description of recent efforts by the facility to offset the deficiency by securing revenue sharing, charity or foundation contributions, or local community support;

6. an analysis of community needs for the service on which the exception request is based;

7. a detailed analysis of the options of the facility if the exception is denied;

8. a plan for future action to respond to the problem; and

9. any other information requested by the deputy commissioner to evaluate the request.

The deputy commissioner may request recommendations from the Commission on a facility's application for exceptional relief. The deputy commissioner may increase the rate, by all or part of the facility's request if the deputy commissioner finds by clear and convincing evidence that the rate established under section IV. and V. of Attachment 4.19-A does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility and that the granting of an exception is in the public interest. In determining whether the exception is in the public interest, the deputy commissioner may consider at least:

1. the necessity of the rate increase to allow reasonable access to quality patient care provided by an efficiently and economically managed facility, including any findings of the governing body of the facility to support the need;
2. the assessment of continued need for this facility's services in the community;

3. whether the facility has taken effective steps to respond to the crisis and has adopted effective management strategies to alleviate or avoid the future need for exceptional relief;

4. the recommendations, if any, from the Commission;

5. the availability of other resources available to the facility to respond to the crisis;

6. whether the relief should have been obtained under the existing rate methodology;

7. other factors relevant to assess reasonable access to quality patient care provided by an efficiently and economically managed facility.

The deputy commissioner will impose conditions on the receipt of exceptional relief including, but not limited to the following:

1. the facility sharing the cost of the rate exception granted;

2. the facility taking effective steps in the future to alleviate the need for future requests for exceptional relief;

3. the facility providing documentation as specified of the continued need for the exception; or

4. a maximum amount of exceptional relief to be granted to the facility under this section.

Amounts granted as exceptional relief shall not be included as part of the base on which future prospective rates are determined. Exceptional relief shall be effective prospectively from the date of the exceptional relief decision and for a period of time not to extend beyond the facility's rate setting year. A facility may apply for and be granted exceptional relief in the following year. A party aggrieved by a decision of the deputy commissioner concerning exceptional relief may request an administrative hearing to the commissioner of the department.

XIII. Public Process

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.